MetLife

Dental

Metropolitan Life Insurance Company

Network: PDP Plus

	HIGH PLAN		LOW PLAN	
Coverage Type	**In-Network** % of Negotiated Fee*	**Out-of-Network** % of R&C Fee**	**In-Network** % of Negotiated Fee*	**Out-of-Network** % of Negotiated Fee**
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	90%	80%	80%	50%
Type C: Major Restorative (bridges, dentures,)	60%	50%	50%	25%
Type D: Orthodontia	50%	50%	50%	50%
Deductible†				
Individual	$50	$100	$100	$150
Family	$150	$300	$300	$450
Annual Maximum Benefit				
Per Person	$2,000	$2,000	$1,250	$1,250
Orthodontia Lifetime Maximum				
Per Person	$1,000	$1,000	$1,000	$1,000

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. R&C is at the 90th percentile.

†Applies to Type A, B and C Services under the Low Plan Out-of-Network. Applies to Type B & C Services under the High Plan and Low Plan In-Network.

Monthly Cost

The following monthly costs are effective beginning January 1, 2023. Your premium will be paid through convenient payroll deduction. Monthly cost covers all eligible children.

Low Plan

Employee Only	$24.02	**Employee + Child(ren)**	$54.28
Employee + Spouse	$48.66	**Employee + Family**	$77.82

High Plan

Employee Only	$45.08	**Employee + Child(ren)**	$101.28
Employee + Spouse	$90.86	**Employee + Family**	$145.00

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

High Plan		**Low Plan**	
Type **A – Preventive**	**How Many/How Often**	**Type A – Preventive**	**How Many/How Often**
Prophylaxis (cleanings)	▪ Two per calendar year	Prophylaxis (cleanings)	▪ Two per calendar year
Oral Examinations	▪ Two exams per calendar year	Oral Examinations	▪ Two exams per calendar year
Topical Fluoride Applications	▪ One fluoride treatment per calendar year for dependent children up to his/her 19th birthday	Topical Fluoride Applications	▪ One fluoride treatment per calendar year for dependent children up to his/her 19th birthday
X-rays	▪ Full mouth X-rays; one per 36 months ▪ Bitewings X-rays two sets per calendar year	X-rays	▪ Full mouth X-rays; one per 36 months ▪ Bitewings X-rays two sets per calendar year
Space Maintainers	▪ Only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion. Recementation of space maintainer performed more than 12 months after the initial insertion	Space Maintainers	▪ Only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion. Recementation of space maintainer performed more than 12 months after the initial insertion
Sealants	▪ Under age 17; limited to permanent molar teeth only, one per tooth per 36-month period	Sealants	▪ Under age 17; limited to permanent molar teeth only, one per tooth per 36-month period
Type B – Basic Restorative	**How Many/How Often**	**Type B – Basic Restorative**	**How Many/How Often**
Fillings	1x per tooth in any 12 consecutive month period.	Fillings	1x per tooth in any 12 consecutive month period.
Simple Extractions	No Limit	Simple Extractions	No Limit
Crown, Denture	Must be more than 12 months	Crown, Denture	Must be more than 12 months

and Bridge Repair/ Recementations	after initial insertion	and Bridge Repair/ Recementations	after initial insertion
Oral Surgery	No Limit	Oral Surgery	No Limit
General Anesthesia	▪ When dentally necessary in connection with oral surgery, extractions or other covered dental services	General Anesthesia	▪ When dentally necessary in connection with oral surgery, extractions or other covered dental services
Type C – Major Restorative	**How Many/How Often**	**Type C – Major Restorative**	**How Many/How Often**
Surgical Extractions	No Limit	Surgical Extractions	No limit
Implants	▪ Replacement once every 5 years	Implants	Not Covered
Bridges and Dentures	▪ Dentures and bridgework replacement; one every 5 years ▪ Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	Bridges and Dentures	▪ Dentures and bridgework replacement; one every 5 years ▪ Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	No limit	Crowns, Inlays and Onlays	No limit
Endodontics	▪ Root canal treatment limited to once per tooth per 12 consecutive months	Endodontics	▪ Root canal treatment limited to once per tooth per 12 consecutive months
Periodontics	▪ Periodontal scaling and root planning once per quadrant, every 24 months ▪ Full mouth debridement once every 60 months	Periodontics	▪ Periodontal scaling and root planning once per quadrant, every 24 months ▪ Full mouth debridement once every 60 months
Type D – Orthodontia	**How Many/How Often**	**Type D – Orthodontia**	**How Many/How Often**
Orthodontia	▪ You, your spouse and your children are covered while Dental insurance is in effect ▪ All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia ▪ Payments are on a repetitive basis ▪ 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary ▪ Orthodontic benefits end at cancellation of coverage	Orthodontia	▪ Your children, up to age 19, are covered while Dental insurance is in effect. ▪ All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia ▪ Payments are on a repetitive basis ▪ 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary ▪ Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

* AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Caries susceptibility tests;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;

- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-855-638-3943 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.